Appendix 8

BEHAVIORAL HEALTH: TEAM REVIEW OF PSYCHOTROPIC MEDICATION
PART ONE: HEALTH SERVICES REPORT
(To be completed by agency/residential staff (e.g. nurse, program specialist) prior to psychotropic medication

INDIVIDUAL:	**DATE-PSYCHOTROPIC MED REVIEW:**
ADDRESS:	**PREVIOUS REVIEW:**
DATE OF BIRTH:	**PHYSICIAN'S NAME:**
CARECO CONTACT:	**OFFICE ADDRESS:**
CONTACT PHONE:	**OFFICE PHONE:**

CURRENT MEDICATIONS *(Please list **all** medications, including over-the-counter, dietary supplements, etc. **Attach additional pages if necessary. Include the individual's name and date of review on every page.**)*

MEDICATION NAME	DOSAGE	FREQUENCY	*Reason for Administration*

ARE THERE ALLERGIES OR CONTRA-INDICATED MEDICATIONS? ☐ NO ☐ YES
*If "**YES**," Specify and describe all symptoms:*

HAS THIS DIAGNOSIS CHANGED? SEE PAGE 3 and check if updated:	**DIAGNOSIS** *(5-Axis Diagnosis from a physician, as documented in medical records)*	**TARGET SYMPTOMS** *(BEHAVIORAL DESCRIPTION)* ***Target Symptoms listed here must match those listed on Part 2***
AXIS I ***(MH Diagnosis)***		
AXIS I (2)		
AXIS II ***(MR Diagnosis)***		
AXIS II ***(Personality Disorder)***		
AXIS III ***(All Medical Diagnoses)***		

AXIS IV *(Psychosocial Stressors)*: as documented by physician/medical records. Notify physician if new issues/changes. **Check all that apply:**
● Problem with primary support group ☐ Problems with access to health care services ☐ Housing problems
☐ Problems related to the social environment ☐ Occupational problems
☐ Economic problems
☐ Educational problems ☐ Problems related to the judicial system
☐ Other psychosocial/environmental problems

AXIS V *(Global Assessment of Functioning/GAF)* ***Score (0-100)_____ (Score provided by physician per DSM scale)***

Last Tardive Dyskinesia Screening (e.g. AIMS test): date and result – required every 6 months)
(Include Score: Date

CURRENT HEALTH STATUS/MEDICAL ISSUES OF NOTE *(Attach significant lab and diagnostic study results):*
***CHECK** all items that were an issue since the last psychotropic medication review. Add comments whenever possible.*

☐●appetite +/-	☐●constipation	☐●dry mouth	☐nausea/vomiting	☐●swelling	☐●alcohol use
☐●bruising	☐●cough	☐●incontinence	☐●seizures	☐●weight +/-	☐●nicotine use
☐●congestion	☐●diarrhea	☐●menstrual change	☐●thirst	☐●pain	☐caffeine use

COMMENTS OR SYMPTOMS NOT INCLUDED IN ABOVE LIST: *(Please describe)* ☐☺other drug use

***Printed** name **and** signature(s) indicating prior psychotropic medication review reports were reviewed in preparing this report.*

Completed by: *(Printed Name and Signature):*	**Title:**	**Date Signed:**
Agency Nurse Review: *(Printed Name & Signature):*	**Title:**	**Date Signed:**

Appendix 8

BEHAVIORAL HEALTH: TEAM REVIEW OF PSYCHOTROPIC MEDICATION

PART TWO: BEHAVIOR SUPPORT TREATMENT REPORT

(To be completed by monitoring team member [behavior specialist, QMRP, program specialist, family member] prior to review.)

INDIVIDUAL:	**DATE-PSYCHOTROPIC MED REVIEW:**

TARGET SYMPTOMS BEING DOCUMENTED

*Include **BEHAVIORAL DESCRIPTIONS** of Target Symptoms for each mental health diagnosis listed on Axis1 on Part 1 of this form. Behavioral descriptions must be **specific to the individual.** For each target symptom, **fill in the number of occurrences for the past month.** Additional charts/graphs may be attached. **Add comments wherever possible.***

Target Symptoms (from Part 1) BEHAVIORAL DESCRIPTION	Month's Data *Fill in frequency of each symptom* **Wk1**	**Wk2**	**Wk3**	**Wk4**	***Comments***
1)					
2)					
3)					
4)					
5)					

ADDITIONAL CONCERNS SINCE LAST REVIEW

Check any symptoms or environmental changes *not being documented above* that have appeared since the last review (clarify in Additional Comments section below)

- ☐ Activity Level (increased or decreased)
- ☐ Anxiety
- ☐ Appetite (Increased or decreased)
- ☐ Change in Mood
- ☐ Obsessive-Compulsive Behavior
- ☐ Sleep Changes
- ☐ Suicidal Ideation/Behavior
- ☐ Environmental Issues
- ☐ Unusual Body Movements (i.e., tremors)
- ☐ Other (Specify:
- ☐ None
- ☐ Psychotic Symptoms

*Were there any **incidents** related to the individual's behavioral health diagnosis or target symptoms? Check the box if so, and insert number of occurrences.*

☐ ER visits? ☐ Psychiatric Hospitalizations? ☐ Restraints?

ADDITIONAL COMMENTS

Signature(s) indicate that prior psychotropic medication review reports were reviewed in preparing this report. *This form can be completed for any appointment but psychotropic medications MUST BE REVIEWED EVERY 30 DAYS MINIMUM.*

SUMMARY COMPLETED BY:	**Date form completed:**
Name:	
Role:	**Date reviewed with team:**
Signature:	**Date reviewed w/prescribing physician:**

Appendix 8

BEHAVIORAL HEALTH: TEAM REVIEW OF PSYCHOTROPIC MEDICATION

PART THREE: PHYSICIAN'S REPORT *(To be completed by physician prescribing psychotropic medication*

INDIVIDUAL:	
DATE OF PRESENT PSYCH MED REVIEW:	**DATE OF NEXT PSYCH MED REVIEW:**

PHYSICIAN'S AGREEMENT WITH CURRENT DIAGNOSES AND TARGET SYMPTOMS: **(see Page 1 and Page 2)**

Do the diagnos(es) in Part 1 and the target symptoms in Part 2 remain as indicated on Part 1: *Health Services Report* and Part 2: *Behavior Support Treatment Report*? ▭ **Yes** ▭ **No**
If **NO**, *please change to:*

TREATMENT GOALS (Regarding Target Symptoms listed on Parts 1 and 2):	**PROGRESS TOWARD GOALS:**

☞	Psychotropic medications are necessary?	❒ Yes	
☞	Psychotropic medication dosages are within usual range?	❒ Yes ❒ No	
☞	Number of drugs conforms to accepted standards?	❒ Yes ❒ No	
☞	Are medication side-effects present? *(i.e., sedation, ataxia, dyscrasia)*	❒ Yes ❒ No	
☞	Screening test performed (i.e., AIMS)?	❒ Yes ❒ No	
☞	Symptoms of T.D. or other E.P.S.?	❒ Yes	
☞	Medication reduction/titration plan considered?	❒ Yes	

PHYSICIAN'S ORDERS

MEDICATION CHANGE: ❒ NO ❒ YES *(provide information below)*

NEW MEDICATION *(List medication, dosage & frequency)*			**REASON FOR NEW MEDICATION**
Medication	**Dosage**	**Frequency**	**Medication Education Provided? ❒Yes ❒No**
1)			
2)			
3)			
MEDICATION CHANGE *(List med. dosage & frequency)*			**REASON FOR MEDICATION**
Medication	**Dosage**	**Frequency**	**CHANGE Medication Education Provided?**
1)			
2)			
3)			
MEDICATION DISCONTINUED *(List med dose, frequency)*			**REASON FOR MEDICATION DISCONTINUATION Medication Education**
Medication	**Dosage**	**Frequency**	**Provided? ❒Yes ❒No**
1)			
2)			
3)			

LAB STUDIES, DIAGNOSTIC TESTS AND FREQUENCIES: Metabolic screening done? ❒Yes ❒No Date:____

COMMENTS/CHANGES/REASONS/AREAS OF CONCERN:

My signature below indicates that I have reviewed the Health Services and Behavior Support Treatment Reports. I have reviewed y recommendations, as well as the consequences to the individual for not following my recommendations with all parties attending this review.

Physician's Printed Name, Signature and Date:	**Clinician: Signature, Title and Date:**

Individual's Consent for Psychotropic Medication: Signature and Date:

Medical Decision-Maker's consent: Signature and Date: